

May 2007

MILITARY HEALTH CARE

TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated



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Highlights of [GAO-07-647](#), a report to congressional committees

Why GAO Did This Study

In light of the fact that Department of Defense (DOD) health care spending more than doubled from 2000 to 2005 and continues to escalate, DOD proposed increasing the share of health care costs paid by TRICARE beneficiaries, under a proposal known as Sustain the Benefit. DOD estimated that if the proposal had been implemented in fiscal year 2007, savings would amount to over \$11 billion through fiscal year 2011. As required by the National Defense Authorization Act for 2007, GAO evaluated (1) the likelihood that DOD would achieve its estimated savings from the proposed enrollment fee and deductible increases for retirees and dependents under age 65, (2) the likelihood that DOD would achieve its estimated savings from the proposed pharmacy co-payment increases for all beneficiaries except active duty personnel, and (3) the factors identified by DOD as contributing to increased TRICARE spending from 2000 to 2005. To conduct its work, GAO examined DOD analyses and interviewed DOD officials. GAO also analyzed data on many aspects of health care costs in general and interviewed health economists.

What GAO Recommends

GAO recommends that DOD collect and compile certain data from TRICARE beneficiaries to help manage its health care spending. In its comments, DOD concurred with this recommendation and with GAO's conclusions.

www.gao.gov/cgi-bin/getrpt?GAO-07-647.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laurie Ekstrand at (202) 512-7101 or ekstrandl@gao.gov.

MILITARY HEALTH CARE

TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated

What GAO Found

Although DOD would likely achieve significant savings if its proposal is implemented, it is unlikely to achieve the \$9.8 billion savings that it expects to receive over 5 years as a result of increased TRICARE enrollment fees and deductibles for retirees and dependents under age 65. DOD's savings estimate depends largely on the assumption that the increased fees and deductibles will result in approximately 500,000 retirees and dependents under age 65 either leaving or choosing not to enroll in TRICARE—collectively referred to as avoided users—and on the assumption that each avoided user will save DOD the equivalent of the cost of providing health care to the average TRICARE beneficiary. However, DOD's projected number of avoided users is likely too high. Many beneficiaries in this group, particularly older and sicker individuals, are unlikely to have lower-priced health insurance options available to them and would therefore be likely to continue to use TRICARE. In addition, DOD's estimated savings per avoided user is likely too high because the estimate does not account for older and sicker individuals, who are less likely to leave or not enroll in TRICARE, and who incur greater-than-average medical expenses. Even without any avoided users, GAO estimates that DOD's proposed fee and deductible increases would achieve at least \$2.3 billion in savings over 5 years. Neither GAO nor DOD can make a more accurate savings estimate, in part because DOD does not collect and compile certain data, such as the cost of other health insurance options. These data, along with information on beneficiaries' access to other health insurance options, could help DOD estimate beneficiary reaction to changes in TRICARE's cost-sharing structure, such as the number of beneficiaries who would become avoided users.

DOD is unlikely to achieve the \$1.5 billion it expects to save by increasing retail pharmacy co-payments for all beneficiaries except active duty personnel. DOD based its estimated savings on a study that measured savings from increased pharmacy co-payments in non-DOD employer-sponsored insurance programs. This study was not analogous to DOD's situation, which resulted in DOD overestimating the reduction in the number of prescriptions obtained from retail pharmacies, and thereby overestimating its savings. Therefore, more beneficiaries may continue to use retail pharmacies and pay higher co-payments, generating more revenue for DOD. However, revenues from these beneficiaries would not offset the higher cost of providing these beneficiaries' prescriptions in retail pharmacies.

DOD attributed its increase in health care spending, from \$17.4 billion in 2000 to \$35.4 billion in 2005, to a number of factors. The factors DOD identified as the largest contributors were medical care inflation and benefit enhancements required by law, including TRICARE for Life, which supplements Medicare coverage for TRICARE beneficiaries, generally after age 65. DOD also identified other factors, including an increased number of beneficiaries who have chosen to use TRICARE and health care costs for mobilized reservists and their families due to the Global War on Terrorism.

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Abbreviations

AHRQ	Agency for Healthcare Research and Quality
BLS	Bureau of Labor Statistics
CalPERS	California Public Employees' Retirement System
CBO	Congressional Budget Office
COLA	cost of living adjustment
CPI	Consumer Price Index
CPI-W	Consumer Price Index for Urban Wage Earners and Clerical Workers
DOD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
GWOT	Global War on Terrorism
Kaiser/HRET	Kaiser Family Foundation and Health Research and Educational Trust
MEPS	Medical Expenditure Panel Survey
MTF	military treatment facility
NDAA	National Defense Authorization Act
OMB	Office of Management and Budget
OPM	Office of Personnel Management
RAND	RAND Corporation
TMOP	TRICARE Mail Order Pharmacy

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United States Government Accountability Office
Washington, DC 20548

May 31, 2007

Congressional Committees

From 2000 to 2005, the Department of Defense's (DOD) spending for health care,¹ which primarily funds TRICARE—its program that provides health care to 9.2 million active duty personnel² and other beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees—more than doubled, from \$17.4 billion to \$35.4 billion.³ DOD projects that its health care spending will continue to rise in coming years and will consume 12 percent of its total budget by 2015,⁴ up from 7.5 percent in 2005. In prior work, we have identified long-term increases in the cost of health care, including TRICARE, as one of the major challenges facing the nation in the 21st century.⁵ We have also previously identified concerns with the sustainability of military benefits, including health care, and recommended that Congress consider restructuring military compensation.⁶

¹While TRICARE is DOD's health care program, its total health care spending includes additional items, such as research and development. All of the DOD spending figures and calculations included in this report relate to fiscal years, rather than calendar years. Figures that appear in this report are generally rounded.

²Reserve personnel who are on active duty orders for a period of more than 30 consecutive days become eligible for TRICARE with the same benefits as active duty personnel. The duration of eligibility may range from up to 90 days before active duty begins to 180 days after active duty ends. The dependents of these reservists also become eligible for several TRICARE options. In this report, we include these mobilized reservists with other active duty personnel and include their dependents with other dependents of active duty personnel.

³TRICARE includes a health maintenance organization option called TRICARE Prime, a preferred-provider organization option called TRICARE Extra, and a fee-for-service option called TRICARE Standard. A separate benefit, TRICARE for Life, supplements Medicare coverage for eligible beneficiaries.

⁴DOD estimates that its health care spending will amount to about \$64 billion in 2015.

⁵GAO, *21st Century Challenges: Reexamining the Base of the Federal Government*, [GAO-05-325SP](#) (Washington, D.C.: February 2005).

⁶GAO, *Military Personnel: DOD Needs to Improve the Transparency and Reassess the Reasonableness, Appropriateness, Affordability, and Sustainability of Its Military Compensation System*, [GAO-05-798](#) (Washington, D.C.: July 19, 2005).

According to DOD, the increase in its health care spending can be attributed to several factors, including growth in the number of TRICARE beneficiaries; the addition of new benefits such as the TRICARE for Life program, which supplements Medicare coverage for TRICARE beneficiaries over age 65;⁷ and increasing costs for prescription drugs. For example, TRICARE spending on prescription drugs increased from \$1.6 billion in 2000 to \$5.4 billion in 2005. DOD health care officials have stated that ensuring that TRICARE remains intact, affordable, and effective is their top priority, and this includes finding ways to manage the growth in DOD's health care spending.⁸

While DOD's health care spending has increased significantly, out-of-pocket expenses paid by many beneficiaries—including enrollment fees, deductibles, coinsurance rates,⁹ and co-payments—have remained relatively unchanged since TRICARE's inception in 1995. For example, a retired beneficiary who is not yet eligible for TRICARE for Life currently pays an annual enrollment fee of \$460 for family coverage in TRICARE Prime, DOD's managed care option—the same fee that was charged in 1995.¹⁰ As a result, the proportion of TRICARE costs paid by beneficiaries has steadily declined since the program was implemented. According to calculations by DOD officials, retirees and dependents under age 65 paid for approximately 27 percent of their overall health care costs in 1996 and about 12 percent of these costs in 2005.¹¹

⁷TRICARE for Life also supplements Medicare coverage for TRICARE beneficiaries under age 65 who qualify for Medicare on the basis of disability or end-stage renal disease and enroll in Medicare Part B.

⁸Department of Defense, *The Military Health System* (Prepared statement for testimony before the Subcommittee on Personnel, Committee on Armed Services, U.S. Senate, April 2005).

⁹Coinsurance is a form of cost sharing between insurer and beneficiary in which the beneficiary pays a percentage of the cost of certain aspects of care. In some of the TRICARE benefit options, for retirees and dependents under age 65, the coinsurance rate for outpatient visits is 20 or 25 percent.

¹⁰The current retirement system requires servicemembers to generally serve 20 years before becoming eligible for nondisability retirement pay and benefits. Retired reserve component personnel are eligible for TRICARE when they reach age 60.

¹¹In this report, we use the phrase retirees and dependents under 65 to refer to military retirees under age 65 and their dependents and survivors under age 65. Survivors include widows, widowers, and certain unmarried children. After age 65, beneficiaries are generally eligible for Medicare with supplementary coverage through TRICARE for Life.

To help address the growth in its health care spending, DOD proposed—as part of the President’s budget proposal for fiscal year 2007—increasing the share of health care costs paid by TRICARE beneficiaries, under a proposal DOD calls Sustain the Benefit. For one group of TRICARE beneficiaries—retirees and dependents under age 65¹²—DOD proposed implementing higher enrollment fees for TRICARE Prime and establishing enrollment fees for beneficiaries who choose not to use TRICARE Prime and instead use either TRICARE’s fee-for-service or preferred-provider options, called TRICARE Standard and TRICARE Extra, respectively. Under the proposal, retirees and dependents under age 65 who use Standard and Extra would also incur higher annual deductibles. DOD proposed phasing in the enrollment fee and deductible increases in fiscal years 2007 and 2008 and then adjusting enrollment fees and deductibles in future years based on the rate of premium increases in the Federal Employees Health Benefits Program (FEHBP), the largest employer-sponsored health insurance program in the country.¹³ Furthermore, DOD has proposed increasing retail pharmacy co-payments in fiscal year 2007 for all TRICARE beneficiaries except active duty personnel—that is, retirees and dependents under age 65, retirees and dependents in TRICARE for Life, and dependents of active duty personnel. The increased co-payments are intended to encourage the use of the TRICARE Mail Order Pharmacy (TMOP) or military treatment facility (MTF) pharmacies and to discourage the use of more costly retail pharmacies. While DOD originally proposed implementing Sustain the Benefit beginning in fiscal year 2007, provisions in the John Warner National Defense Authorization Act for Fiscal Year 2007 (NDAA for 2007)¹⁴ prevent DOD from implementing the proposal before October 1, 2007.¹⁵ The proposal’s implementation after that date remains uncertain; DOD officials are awaiting the recommendations of the Task Force on the Future of Military Health Care, a group established by DOD and required by the NDAA for

¹²The proposed increases in enrollment fees and deductibles do not apply to beneficiaries in TRICARE for Life, including TRICARE for Life beneficiaries who may be under age 65 but who are eligible for Medicare on the basis of disability or end-stage renal disease.

¹³The Office of Personnel Management (OPM) administers FEHBP by contracting with multiple health insurance carriers to offer health plans for federal employees enrolled in the program. OPM negotiates benefits and premium rates with each carrier.

¹⁴See Pub. L. No. 109-364, §§ 704, 708, 120 Stat. 2083, 2280, and 2284 (2006).

¹⁵The proposal remained as part of the President’s budget proposal for fiscal year 2008.

2007 to make interim recommendations on TRICARE's cost-sharing structure by May 31, 2007.¹⁶

DOD estimated that if the proposal had been implemented beginning in fiscal year 2007 as planned, savings from these changes—in the form of reduced costs and increased revenues¹⁷—would amount to over \$11 billion through fiscal year 2011, including \$9.8 billion from the effects of enrollment fee and deductible increases and \$1.5 billion from pharmacy co-payment increases. DOD estimated that these savings would largely be the result of current users leaving TRICARE or potential users choosing not to enroll in TRICARE—and choosing other health care options—because of the higher enrollment fees and deductibles. Collectively, DOD refers to these individuals as avoided users.

Advocacy groups for military beneficiaries have raised concerns over the analyses that led DOD to propose increasing beneficiaries' out-of-pocket costs. The advocacy groups have questioned DOD's accounting of the factors that have driven increases in DOD's health care spending as well as the amount of projected savings from the Sustain the Benefit proposal. The NDAA for 2007 required that we review DOD's proposal.¹⁸ Specifically, as discussed with the committees of jurisdiction, we examined (1) the likelihood that DOD would achieve its estimated savings associated with the proposed enrollment fee and deductible increases for retirees and dependents under age 65, (2) the likelihood that DOD would achieve its estimated savings associated with the proposed pharmacy co-payment increases for all beneficiaries except active duty personnel, and (3) the factors identified by DOD as contributing to the increase in its health care spending from 2000 to 2005. The act also required us to review DOD's calculations of the proportion of TRICARE's health care costs paid by retirees and dependents under 65. This information is included in appendix I. Furthermore, the act required that we describe how DOD's annual rate of medical care inflation—that is, the rate at which prices rise and purchasing power falls for a fixed set of medical goods and services—compares with increases in health insurance premium growth trends and broader indicators of inflation from 2001 through 2005. We provide this

¹⁶See Pub. L. No. 109-364, § 711, 120 Stat. 2083, 2284-87 (2006).

¹⁷DOD refers to offsetting collections from enrollment fees, deductibles, and co-payments as revenue. We have adopted this term for the purposes of this report.

¹⁸See Pub. L. No. 109-364, § 713(a), 120 Stat. 2083, 2288-89 (2006).

information in appendix II. We did not examine other challenges that might be faced by DOD in managing TRICARE spending, but instead limited our scope to those areas prescribed by the NDAA for 2007.

To examine the likelihood that DOD would achieve its estimated savings associated with the proposed enrollment fee and deductible increases for retirees and dependents under age 65 and the proposed pharmacy co-payment increases for all beneficiaries except active duty personnel, we reviewed the analyses prepared by DOD and a DOD contractor that projected cost savings from these increases. We also interviewed DOD officials, reviewed relevant economic literature, and consulted with several health economists about DOD's assumptions and methodology for making the savings estimates. As part of our review of DOD's savings estimates, we used survey data from the RAND Corporation (RAND) on military retirees' options for obtaining health insurance, survey data from the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET) on employer-sponsored health insurance premiums, and survey data from the Agency for Healthcare Research and Quality on the health care costs for the U.S. population. We also reviewed a draft report prepared by RAND on the health insurance options of military retirees and Kaiser/HRET reports on employer health benefits.

To examine the factors identified by DOD as contributing to the increase in DOD health care spending, we reviewed the factors DOD identified as contributing to the increase in its health care spending from 2000 to 2005, including TRICARE's rate of medical care inflation.¹⁹ We determined that the spending data provided by DOD were sufficiently reliable for our purposes, but we did not independently verify DOD's figures. In most cases, DOD provided estimates instead of actual spending data, a practice on which we have previously reported. We made recommendations to DOD in a previous report to improve the reliability and reporting of its costs.²⁰ DOD officials told us that in many cases the department does not have the information systems necessary to precisely determine actual

¹⁹Medical care inflation represents cost increases for delivering a fixed set of medical goods and services. Medical care inflation is distinguished from other cost increases in health care that can result from changing medical goods and services, such as expanding health benefits or an increase in the number of beneficiaries.

²⁰GAO, *Global War on Terrorism: DOD Needs to Improve the Reliability of Cost Data and Provide Additional Guidance to Control Costs*, [GAO-05-882](#) (Washington, D.C.: Sept. 21, 2005), and *Global War on Terrorism: Observations on Funding, Costs, and Future Commitments*, [GAO-06-885T](#) (Washington, D.C.: July 18, 2006).

spending for specific activities. We also interviewed DOD officials and reviewed relevant literature on medical care inflation. To assess the reliability of the data used by DOD to project savings for Sustain the Benefit and identify the factors influencing increased DOD health care spending, we interviewed DOD officials and tested the data for errors. We determined that the data were sufficiently reliable for our purposes. As required by the NDAA for 2007, we cooperated with the Congressional Budget Office (CBO) to conduct our work. We periodically discussed our progress with and obtained advice from CBO officials, particularly concerning our review of DOD's savings estimates.

We conducted our work from July 2006 through May 2007 in accordance with generally accepted government auditing standards. See appendix III for more information about our scope and methodology.

Results in Brief

If Sustain the Benefit is implemented, DOD is unlikely to achieve the \$9.8 billion savings that it expects over 5 years as a result of higher TRICARE enrollment fees and deductibles aimed at retirees and dependents under age 65, but it is still likely to achieve significant savings. DOD's savings estimate depends largely on the assumption that the increased fees and deductibles will result in approximately 500,000 retirees and dependents under age 65 either leaving or choosing not to enroll in TRICARE—collectively referred to as avoided users—and on the assumption that each avoided user will save DOD the equivalent of the cost of providing health care to the average TRICARE beneficiary. However, DOD's projected number of avoided users is likely too high. Many beneficiaries in this group, particularly older and sicker individuals, are unlikely to have lower-priced health insurance options available to them and would therefore be likely to continue to use TRICARE. In addition, DOD's estimated savings per avoided user is also likely too high because the estimate does not account for the fact that the older and sicker individuals who are less likely to leave or not enroll in TRICARE also incur greater-than-average medical expenses. CBO officials reviewed DOD's savings estimates and our analysis and agreed that DOD's estimates were likely too high. Nevertheless, even with no avoided users, we estimate that DOD's proposed fee and deductible increases would likely achieve a minimum of \$2.3 billion in savings over 5 years, in the form of revenue collected from higher enrollment fees and deductibles. DOD's savings will likely be higher than this minimum because Sustain the Benefit should result in some avoided users. However, neither we nor DOD are able to make a more accurate estimate of these savings, in part because DOD does not collect and compile certain data, such as the cost

of other health insurance options available to beneficiaries. These data, along with information on beneficiaries' access to other health insurance options, could help DOD estimate how TRICARE beneficiaries would react to changes in TRICARE's cost-sharing structure, such as the number of beneficiaries who would become avoided users because of increased fees and deductibles.

DOD would also be unlikely to achieve the \$1.5 billion it expects to save by increasing retail pharmacy co-payments for all beneficiaries except active duty personnel. According to DOD officials, DOD based its estimated savings on a study that measured savings from increased pharmacy co-payments in non-DOD employer-sponsored insurance programs.²¹ DOD used the decrease in costs reported by the study to estimate the likely decrease in the number of TRICARE retail prescriptions resulting from the proposed changes. However, doing so resulted in an overestimate of the likely reduction in the number of prescriptions that would be obtained from retail pharmacies because of the increased co-payments—and therefore an overestimate of savings—because some savings in the study resulted from beneficiaries switching from brand-name to generic drugs. Because DOD already generally requires the use of generic drugs when available, it cannot expect to receive significant additional savings from a shift to generic drugs. If fewer beneficiaries than DOD projected choose to reduce retail pharmacy use, then more beneficiaries would pay the higher co-payments, generating more revenue for DOD. However, increased revenues from these beneficiaries would not be large enough to offset the higher cost to DOD of providing these beneficiaries' prescriptions in retail pharmacies.

DOD attributed the increase in its health care spending, from \$17.4 billion in 2000 to \$35.4 billion in 2005, to a number of factors. The factors DOD identified as the largest contributors were medical care inflation and benefit enhancements required by law, including TRICARE for Life. DOD also identified other factors, including an increase in the number of TRICARE beneficiaries who have chosen to use TRICARE and increased health care costs because of the Global War on Terrorism (GWOT), such as DOD's costs of providing health care for mobilized National Guard and Reserve personnel and their families.

²¹G.F. Joyce and others, "Employer Drug Benefit Plans and Spending on Prescription Drugs," *JAMA*, vol. 288, no. 14 (2005): 1733-1739.

To help DOD manage its health care spending, we are recommending that DOD routinely collect and compile certain information that could help DOD identify the reasons why beneficiaries may or may not choose to use TRICARE, including information on beneficiaries' access to and costs of other health insurance.

In its written comments on a draft of this report, DOD concurred with our conclusions and recommendation. See appendix IV for DOD's comments. DOD also provided technical comments, which we incorporated as appropriate.

Background

DOD's TRICARE program, which was established in 1995,²² offers health care benefits to active duty personnel and other beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees. Beneficiaries receive care at MTFs or from civilian providers. TRICARE beneficiaries can obtain prescription drugs through TRICARE's pharmacy system, which includes MTF pharmacies, network retail pharmacies, nonnetwork retail pharmacies, or TMOP.

Dependents of active duty personnel and retirees and dependents under age 65 can choose to enroll in TRICARE Prime (managed care option), or if they choose not to enroll, they can obtain care through TRICARE Standard (fee-for-service option) or TRICARE Extra (preferred-provider option). Active duty personnel are generally required to enroll in TRICARE Prime.²³ Enrollees in TRICARE Prime, except for active duty beneficiaries and their family members, pay an annual enrollment fee, which is the same regardless of a retired beneficiary's rank. Beneficiaries who do not enroll in TRICARE Prime can receive care subject to an annual deductible and other cost shares. When these unenrolled beneficiaries use providers outside the TRICARE network, they pay higher cost shares and are considered to be using TRICARE Standard. When they use providers who are part of the TRICARE network, they pay discounted cost shares and are considered to be using TRICARE Extra. Before 2001, DOD provided health care for beneficiaries eligible for the Medicare program—typically those

²²Prior to 1995, DOD provided health benefits under a different system, the Civilian Health and Medical Program of the Uniformed Services.

²³DOD officials told us that some active duty beneficiaries are not required to enroll in TRICARE Prime. However, DOD still considers these beneficiaries to be covered by TRICARE Prime.

over age 65—at MTFs on a space-available basis. The National Defense Authorization Act for Fiscal Year 2001 established TRICARE for Life to provide supplementary health care coverage for TRICARE beneficiaries enrolled in the Medicare program.²⁴ All TRICARE beneficiaries except active duty personnel pay co-payments for prescription drugs obtained through retail pharmacies or TMOP. MTF pharmacies do not charge co-payments.

DOD's Proposed Sustain the Benefit Initiative

As part of the President's fiscal year 2007 budget proposal, DOD proposed increasing certain TRICARE fees through its Sustain the Benefit initiative. Under the proposal, for retirees and dependents under age 65, DOD would increase enrollment fees for TRICARE Prime and establish enrollment fees and higher annual deductibles for TRICARE Standard and TRICARE Extra.²⁵ DOD proposed different fee and deductible levels for retired officers and their dependents, retired senior enlisted personnel (E-7 and above) and their dependents, and retired junior enlisted personnel (E-1 to E-6) and their dependents. DOD has proposed phasing in enrollment fee and deductible increases in fiscal year 2007 and fiscal year 2008 that are generally lower than the total percentage increase in premiums over the past 10 years for FEHBP; these premiums are negotiated by the Office of Personnel Management. DOD proposed adjusting enrollment fee and deductible increases based on the annual rate of premium increases in FEHBP beginning in fiscal year 2009.

Provisions in the NDAA for 2007 prevent DOD from implementing its proposal before October 1, 2007. The act also requires DOD to establish the Task Force on the Future of Military Health Care and requires the task force to make interim recommendations by May 31, 2007, on the beneficiary and government cost-sharing structure needed to sustain

²⁴See Pub. L. No. 106-398, §§ 712-713, 114 Stat. 1654, 1654A-176 to 1654A-184 (2000). TRICARE for Life covers beneficiaries who are eligible for Medicare Part A, which helps cover inpatient care in hospitals, and who are enrolled in Medicare Part B, which helps cover medical services such as doctors' services and outpatient care. It acts as a secondary payer to Medicare and pays for many services that Medicare only partially covers or does not cover. While TRICARE beneficiaries do not have to pay for their TRICARE for Life coverage, they pay premiums to be enrolled in Medicare Part B. Some TRICARE beneficiaries under age 65 are eligible for Medicare on the basis of disability or end-stage renal disease, and therefore are also eligible for TRICARE for Life.

²⁵Outpatient deductibles for TRICARE Standard and Extra are currently capped by law at \$150 annually for single beneficiaries and \$300 annually for families. See 10 U.S.C. § 1086(b).

TRICARE's health benefits over the long term. The Sustain the Benefit proposal was also included as part of the President's fiscal year 2008 budget proposal, but DOD officials expect to await the recommendations of the task force before deciding on the future of the proposal. Table 1 lists DOD's proposed enrollment fees for TRICARE Prime.

Table 1: TRICARE Prime Proposed Enrollment Fees for Military Retirees and Dependents under Age 65

		Annual enrollment fees			FY 09 and future years
		FY 95-FY 06	FY 07	FY 08	
Retired junior enlisted ^a	Self	\$230	\$275	\$325	Fees for all adjusted based on FEHBP
	Family	460	550	650	
Retired senior enlisted ^b	Self	230	350	475	
	Family	460	700	950	
Retired officer	Self	230	500	700	
	Family	460	1,000	1,400	

Source: DOD.

^aRetired junior enlisted is defined as military grades E-1 to E-6.

^bRetired senior enlisted is defined as military grades E-7 and above.

Table 2 lists DOD's proposed enrollment fees and deductibles for TRICARE Standard and Extra.

Table 2: TRICARE Standard and Extra Proposed Enrollment Fee and Deductible Increases for Military Retirees and Their Dependents under Age 65

		Annual enrollment fee				Annual outpatient deductible			
		FY 95-FY 06	FY 07	FY 08	FY 09 and future years	FY 95-FY 06	FY 07	FY 08	FY 09 and future years
Retired junior enlisted	Self	\$0	\$75	\$140	Fees for all adjusted based on FEHBP	\$150	\$175	\$185	Fees for all adjusted based on FEHBP
	Family	0	150	280		300	350	370	
Retired senior enlisted	Self	0	100	200		150	175	185	
	Family	0	200	400		300	350	370	
Retired officer	Self	0	150	280		150	225	280	
	Family	0	300	560		300	450	560	

Source: DOD.

In addition, for all beneficiaries except active duty personnel—that is, for retirees and dependents under age 65, retirees and dependents in TRICARE for Life, and dependents of active duty personnel, the proposal includes increasing retail pharmacy co-payments and eliminating co-payments for generic drugs in TMOP (see table 3).²⁶ The proposal would not change other TRICARE provisions that affect beneficiaries’ costs, such as cost shares for inpatient and outpatient care or the annual limit on beneficiaries’ costs, known as the catastrophic cap.²⁷

²⁶Retirees and dependents in TRICARE for Life are eligible to obtain prescription drugs through TRICARE, including from retail pharmacies, TMOP, and MTF pharmacies. According to DOD, for nearly all TRICARE for Life beneficiaries, under most circumstances, there is no added value in purchasing Medicare prescription drug coverage, referred to as Medicare Part D.

²⁷Specifically, the catastrophic cap is the maximum out-of-pocket expense for which TRICARE beneficiaries are responsible in a given fiscal year. As of March 2007, the catastrophic cap for active duty families was \$1,000 and the catastrophic cap for all other TRICARE-eligible families was \$3,000. The catastrophic cap applies only to services covered by TRICARE.

Table 3: Proposed TRICARE Pharmacy Co-payments for All Beneficiaries Except Active Duty

Delivery option	Supply	Current co-payments			Proposed co-payments		
		Generic	Brand	Nonformulary	Generic	Brand	Nonformulary
Military treatment facility	Up to 90 days	None	None	Not applicable	None	None	Not applicable
TRICARE Mail Order Pharmacy	Up to 90 days	\$3	\$9	\$22	\$0	\$9	\$22
Retail network pharmacy	Up to 30 days	\$3	\$9	\$22	\$5	\$15	\$22
Retail nonnetwork pharmacy, TRICARE Standard and Extra	Up to 30 days	Greater of \$9 or 20 percent of total cost		Greater of \$22 or 20 percent of total cost	Greater of \$15 or 20 percent of total cost		Greater of \$22 or 20 percent of total cost
Retail nonnetwork pharmacy, TRICARE Prime	Up to 30 days	50 percent		50 percent	50 percent		50 percent

Source: DOD.

Note: Retirees and dependents in TRICARE for Life are eligible to obtain prescription drugs through TRICARE, including from retail pharmacies, TMOP, and MTF pharmacies.

Rationale for Sustain the Benefit

DOD designed the Sustain the Benefit proposal to slow the increases in its health care spending, which more than doubled from \$17.4 billion in 2000 to \$35.4 billion in 2005. A portion of this increase was caused by prescription drug spending, which increased from \$1.6 billion in 2000 to \$5.4 billion in 2005. While TRICARE spending has increased, many fees paid by beneficiaries, such as enrollment fees, deductibles, and co-payments, have remained virtually unchanged since the program's inception. In particular, TRICARE Prime enrollment fees have remained at \$230 for single beneficiaries and \$460 for families since 1995, and TRICARE Standard and Extra have never had an enrollment fee.²⁸ In addition, enhancements to the TRICARE benefit required by law, such as the reduction of the TRICARE Standard and Extra catastrophic cap for retirees and dependents under age 65, have further limited beneficiaries' out-of-pocket costs, thereby increasing DOD's share of TRICARE costs.²⁹

²⁸ Active duty beneficiaries and their family members do not pay enrollment fees.

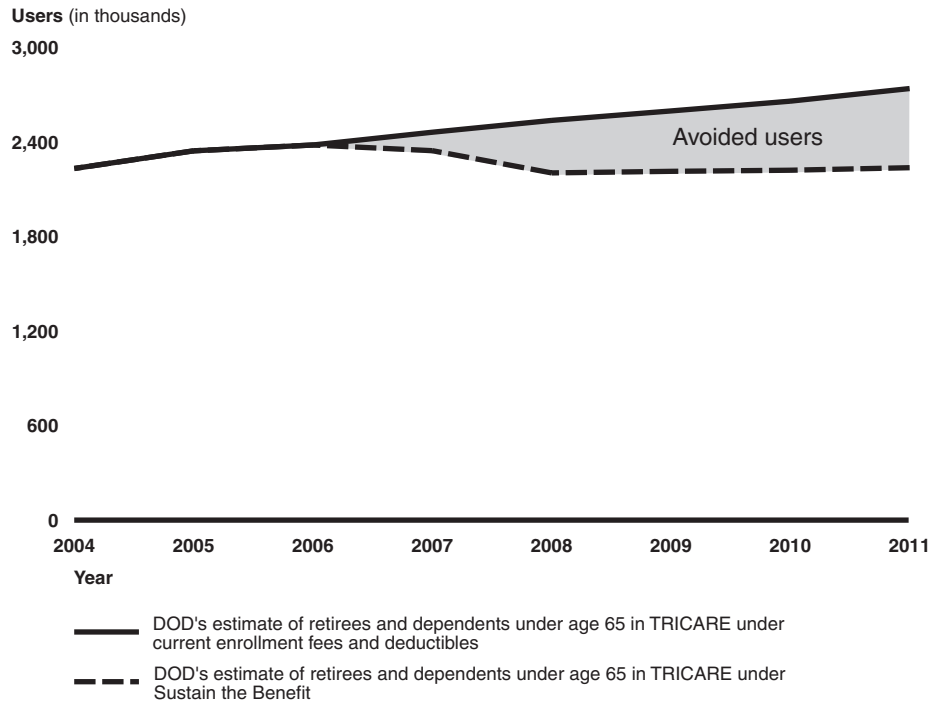
²⁹ The Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 lowered the maximum allowable catastrophic cap for retirees and dependents under age 65 in TRICARE Standard and Extra from \$7,500 to \$3,000. See Pub. L. No. 106-398, § 759, 114 Stat. 1654, 1654A-200 (2000), codified at 10 U.S.C. § 1086(b)(4).

DOD's increased health care costs, combined with the largely unchanged average out-of-pocket costs for TRICARE beneficiaries, have led to a decreasing portion of TRICARE costs being paid by beneficiaries. To explain the need for Sustain the Benefit, DOD officials said that military retirees and dependents under age 65—the group that would be affected by enrollment fee and deductible increases—paid approximately 27 percent of their health care costs covered by TRICARE in 1996 and about 12 percent of these costs in 2005. For more information on DOD's calculation of these figures, see appendix II.

From 1996 to 2005, average out-of-pocket expenses paid by TRICARE beneficiaries remained relatively unchanged, while average out-of-pocket expenses for enrollees in FEHBP and other employer-sponsored health insurance increased, largely in the form of higher premiums. For example, an enrollee's share of the average FEHBP premium, when weighted by the proportion of enrollees with single and family coverage, nearly doubled in 9 years, from about \$1,148 in 1996 to about \$2,260 in 2005. In contrast, the TRICARE Prime enrollment fees, when weighted by the number of enrollees with single and family coverage, amounted to \$437 in 1996 and remained at \$437 in 2005.

According to DOD, increasing enrollment fees and deductibles would reduce the price gap between civilian health insurance premiums and TRICARE enrollment fees, thereby reducing the incentive for retirees and dependents under age 65 to choose TRICARE over other health insurance options. DOD officials estimate that by 2011, the proposed increases in enrollment fees and deductibles would generate over 500,000 avoided users. (See fig. 1.)

Figure 1: DOD's Projected Number of Retirees and Dependents under Age 65 Who Would Use TRICARE under the Sustain the Benefit Proposal and under Current Policy, 2004-2011



Source: GAO analysis of DOD data.

DOD officials told us that they want to increase enrollment fees and deductibles for retirees and dependents under age 65 because these beneficiaries are more likely than other beneficiaries to have other health insurance options and therefore are more likely to leave or choose not to enroll in TRICARE. DOD officials said that they did not consider implementing enrollment fees and deductibles for active duty personnel or increasing deductibles for their dependents to avoid affecting military readiness. DOD officials also did not consider establishing enrollment fees for retirees and dependents in TRICARE for Life because they believe that the fact that the TRICARE for Life benefit was recently established suggests that Congress would not be likely to approve enrollment fees for those beneficiaries. In addition, DOD officials told us that they proposed FEHBP as the basis for the proposed increase amounts because its premiums are driven by the private insurance market and are calculated

outside of DOD by the Office of Personnel Management.³⁰ DOD officials did not want to use DOD data to set rate increases because they wanted to avoid any appearance that the data might be manipulated to DOD's financial advantage.

To discourage TRICARE users from obtaining prescriptions at high-cost retail pharmacies, DOD officials chose to increase co-payments for prescriptions dispensed at retail pharmacies for all beneficiary groups except active duty personnel. We previously reported that in 2004, DOD spent over 50 percent—about \$2.4 billion—of its pharmacy costs on prescriptions dispensed through retail pharmacies, even though these prescriptions account for less than 30 percent of its total number of prescriptions.³¹ DOD's reported cost per prescription varies among retail pharmacies, TMOP, and MTF pharmacies for a number of reasons, including differences in the price of drugs dispensed in each system, co-payments, and the administrative costs of dispensing the drugs. For example, DOD receives discounted drug prices for drugs it purchases and then dispenses through MTFs or TMOP, but does not receive these discounts when beneficiaries obtain drugs through retail pharmacies. Therefore, DOD's costs for purchases at retail pharmacies are generally higher than at MTFs or through TMOP.

DOD's Projected Savings from Sustain the Benefit

DOD projected that implementing the Sustain the Benefit proposal would lead to a total savings of more than \$11 billion over a 5-year period, from 2007 through 2011. DOD projected that the effects of the proposed increases in enrollment fees and deductibles for retirees and dependents under age 65 would account for approximately \$9.8 billion of these savings, while the effects of proposed increases in pharmacy co-payments

³⁰For more information on how FEHBP costs are calculated, see GAO, *Federal Employees Health Benefits Program: Premium Growth Has Recently Slowed, and Varies Among Participating Plans*, [GAO-07-141](#) (Washington, D.C.: Dec. 22, 2006).

³¹See GAO, *Mail Order Pharmacies: DOD's Use of VA's Mail Pharmacy Could Produce Savings and Other Benefits*, [GAO-05-555](#) (Washington, D.C.: June 22, 2005).

for dependents of active duty personnel and retirees and dependents under age 65 would account for about \$1.5 billion of the savings.³²

Specifically, DOD estimated that \$7.6 billion of the \$9.8 billion in savings from the proposed increases in enrollment fees and deductibles would result from avoided users—current beneficiaries choosing to leave TRICARE or potential beneficiaries choosing not to enroll. DOD also expected that some beneficiaries who choose to use TRICARE Standard or Extra would be influenced by the proposal’s higher deductibles to use fewer health care services, leading to about \$361 million of the \$9.8 billion of expected savings. Finally, DOD expected that \$1.9 billion of the \$9.8 billion in savings would come from the higher enrollment fees and deductibles collected from beneficiaries who continue to use TRICARE.³³

DOD also projected that the \$1.5 billion in savings from increased pharmacy co-payments would result from three factors: (1) reductions in the overall number of prescriptions for TRICARE beneficiaries filled at retail pharmacies, (2) a shift of prescriptions from higher-cost retail pharmacies to lower-cost MTF pharmacies or TMOP, and (3) increased revenues from higher co-payments. DOD officials expected that the first two factors would account for about \$982 million in savings. DOD officials expected that the third factor would produce savings of \$486 million, in the form of co-payments collected from beneficiaries who choose to use retail pharmacies.

³²DOD also expects that there will be savings of \$1.5 billion over 5 years because of pharmacy co-payment increases for retirees and dependents over 65 in TRICARE for Life. However, DOD officials told us that they did not include this amount in DOD’s estimate of savings because TRICARE for Life costs are paid through the Department of Defense Medicare Eligible Retiree Health Care Fund. See 10 U.S.C. §§ 1111 et seq.

³³Numbers do not total precisely because of rounding.

DOD Is Unlikely to Achieve \$9.8 Billion in Savings as a Result of Increased Enrollment Fees and Deductibles, though Significant Savings Can Be Expected

DOD is unlikely to achieve the \$9.8 billion it expects to save as a result of higher TRICARE enrollment fees and deductibles because it overestimated the number of avoided users the increases would likely generate. The number of avoided users is likely to be lower than DOD estimated because for many military retirees and dependents under age 65, TRICARE may be the only option or may still be the lowest-cost option for health insurance. DOD also overestimated the amount of savings that could be attributed to each avoided user. If no current TRICARE users leave TRICARE and no potential users choose not to enroll as a result of the proposed cost-share increases, collection of the higher enrollment fees and deductibles from a greater number of users would likely amount to a minimum of \$2.3 billion in savings through 2011. DOD's savings would be higher than \$2.3 billion to the extent that DOD generates avoided users. However, because DOD does not collect and compile certain information from its beneficiaries—such as data on the cost of other health insurance options available to TRICARE beneficiaries that could help DOD estimate beneficiaries' reaction to changes in TRICARE's cost-sharing structure—neither we nor DOD are able to make a more accurate estimate.

DOD Overestimated the Number of Avoided Users That Would Likely Result from Higher Fees and Deductibles

DOD is unlikely to achieve the \$9.8 billion it expects to save over 5 years from the effects of higher TRICARE enrollment fees and deductibles aimed at retirees and dependents under age 65, largely because the department likely overestimated the number of avoided users that the change would generate. DOD projected that the proposed increase in fees and deductibles would generate approximately 500,000 avoided users in 5 years. The department based this projection on a RAND review of studies that examined how individuals enrolled in employer-sponsored health insurance have responded to premium increases.³⁴ The studies RAND reviewed showed that most individuals who left health insurance plans when faced with increases in their health insurance premiums switched to lower-priced health insurance plans. DOD officials recognized that TRICARE beneficiaries often would lack lower-priced health insurance alternatives and therefore relied on one of the studies in the RAND review that showed the lowest level of beneficiary responsiveness to premium increases. However, even in this study, the individuals who left their health insurance plans in response to premium increases had lower-priced health insurance options to choose from, an option that many

³⁴J.S. Ringel and C. Eibner, *Health Care Demand Elasticities and Their Implications for Military Health Cost Containment* (RAND Corporation: 2004).

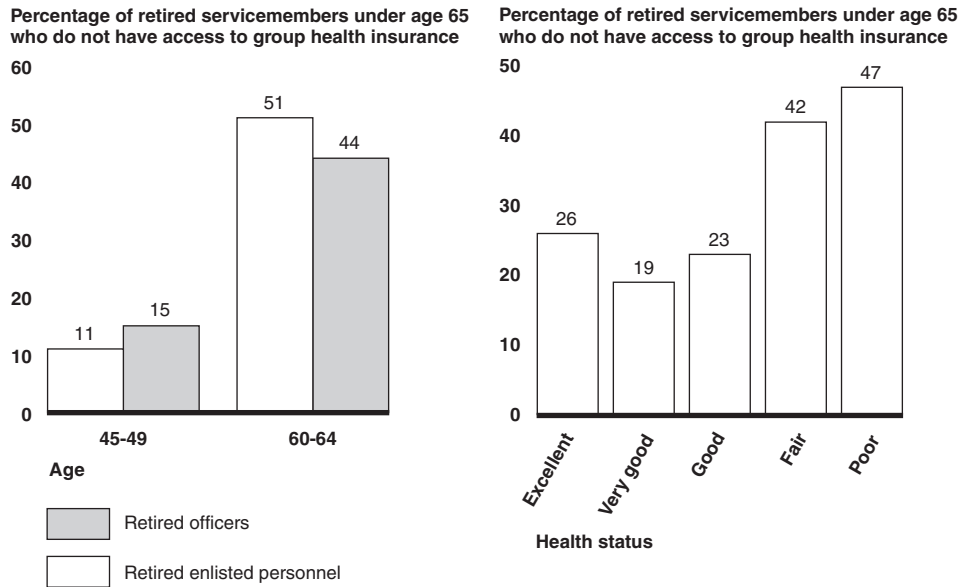
TRICARE beneficiaries would be unlikely to have. Therefore, DOD's projected number of avoided users is probably too high. CBO officials reviewed DOD's savings estimates, including its estimates of the number of avoided users, and agreed that these estimates were likely too high.

In its savings estimates, DOD did not develop separate measures of responsiveness to enrollment fee and deductible increases for various groups within the population of retirees and dependents under age 65, such as those who are older or less healthy than average, but instead applied an average measurement of price sensitivity to the population as a whole. However, for some retirees and dependents under age 65, TRICARE is the only option for group health insurance through an employer, a spouse's employer, or a professional association. For these TRICARE beneficiaries, the proposed increases in enrollment fees and deductibles are unlikely to make them leave TRICARE and become avoided users. According to a draft report compiled in 2006 by RAND, around 21 percent of retired enlisted and 27 percent of retired officers reported that they do not have access to group health insurance.³⁵ Because these individuals do not have access to group health insurance, they are unlikely to have access to health insurance plans that are less expensive than TRICARE.³⁶ The lack of group health insurance options is even more pronounced for retirees who reported being older or less healthy than average, making these beneficiaries even less likely than others to become avoided users. According to the RAND survey, 51 percent of retired enlisted personnel ages 60-64 and 44 percent of retired officers in that age group reported not having access to group health insurance, compared with 11 percent of retired enlisted personnel ages 45-49 and 15 percent of retired officers in that age group. Similarly, 47 percent of military retirees under age 65 in poor health reported not having access to group health insurance through any of these sources, compared with 26 percent of those in excellent health. (See fig. 2.)

³⁵Louis T. Mariano and others, *Civilian Health Insurance Options of Military Retirees: Findings from a Pilot Survey*, Draft (RAND Corporation: August 2006).

³⁶These individuals may have access to health insurance plans on the individual market, but premiums for these plans are, for the most part, more expensive than the premiums they would pay for group health insurance.

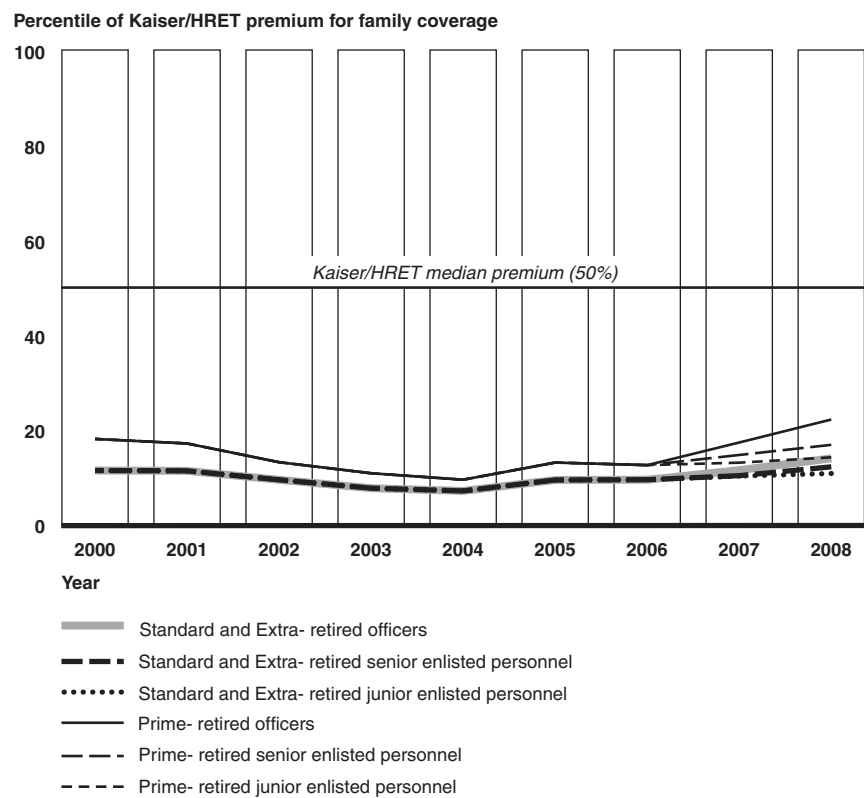
Figure 2: Percentage of Military Retirees under Age 65 Reporting Not Having Access to Civilian Group Health Insurance by Age and Health Status, 2006



In addition, for many retirees and dependents under age 65 with access to group health insurance, TRICARE may be the lowest-cost option for health insurance, even when DOD's proposed fee increases are taken into account. According to the 2006 Kaiser/HRET Employer Health Benefits Annual Survey, the average employer-sponsored insurance premium paid by enrollees in 2006 was \$2,973 for family coverage and \$627 for single coverage. Under DOD's Sustain the Benefit proposal, enrollment fees for TRICARE, including Prime, Standard, and Extra, in 2008 would largely remain below this average and range from \$280 to \$1,400 for family coverage and \$140 to \$700 for single coverage, depending on the primary beneficiary's rank (retired junior enlisted personnel, retired senior enlisted personnel, or retired officer) and choice of TRICARE benefit option (Prime or Standard and Extra). For example, if the average employer-sponsored insurance premium paid by enrollees remains unchanged from 2006 to 2008, only about 22 percent of employer-sponsored insurance premiums for family coverage would be lower than or equal to the

proposed enrollment fees to be paid by retired officers enrolled in TRICARE Prime in that year (see fig. 3).³⁷

Figure 3: Comparison of Proposed TRICARE Enrollment Fees with Kaiser/HRET-Reported Employee Shares of Employer-Sponsored Insurance Premiums, Family Coverage, 2000-2008



Source: GAO analysis of Kaiser/HRET data.

Another factor limiting the number of avoided users that DOD is likely to achieve is the fact that DOD's proposed enrollment fee and deductible increases will not affect retirees and their dependents under 65 who have annual out-of-pocket health care costs greater than \$3,000. All enrollment fees and deductibles paid by TRICARE beneficiaries count toward

³⁷If employer-sponsored insurance premiums increase from 2006 to 2008, then these percentages would be even lower.

TRICARE's catastrophic cap of \$3,000 per family.³⁸ If DOD increases TRICARE enrollment fees and deductibles, more TRICARE beneficiaries will reach the cap. For those who reach the cap, there will be no additional out-of-pocket costs for TRICARE, even if fees and deductibles continue to rise. Therefore, the proposed fee and deductible increases may be limited in their ability to generate avoided users, especially among high-cost users who anticipate exceeding the cap.³⁹

DOD Likely Overestimated the Savings Associated with Each Avoided User

In addition to overestimating the number of avoided users, DOD also overestimated the savings that it would be likely to achieve from each avoided user. In projecting \$7.6 billion in savings over 5 years from avoided users, DOD calculated that each year, the average avoided user would result in savings equivalent to DOD's annual cost of providing health care to the average TRICARE retiree or dependent under age 65.⁴⁰ However, this calculation is likely too high, for two reasons. First, as previously discussed, beneficiaries who are older and sicker than average are less likely than others to become avoided users. Therefore, avoided users would likely have lower-than-average health care costs, reducing DOD's savings. As previously noted, beneficiaries who anticipate meeting the catastrophic cap for their out-of-pocket expenses—and this group includes beneficiaries who tend to be older and sicker than average—have little incentive to become avoided users in response to increased enrollment fees and deductibles. Similarly, studies on individuals' choices of health insurance have concluded that older and sicker individuals are

³⁸Specifically, the catastrophic cap is the maximum out-of-pocket expense for which TRICARE beneficiaries are responsible in a given fiscal year. As of March 2007, the catastrophic cap for active duty families was \$1,000 and the catastrophic cap for all other TRICARE-eligible families was \$3,000. The catastrophic cap applies only to services covered by TRICARE.

³⁹DOD estimated that approximately 20 percent of families in Standard and Extra would exceed the cap from 2007 to 2011. These beneficiaries are generally responsible for the highest health care costs among Standard and Extra beneficiaries.

⁴⁰For example, for 2007, DOD determined that the projected annual cost of providing health care for the average retiree and dependent under 65 was \$3,924 for TRICARE Prime users and \$3,173 for TRICARE Standard and Extra users.

less likely than those of average health to leave a health insurance plan in response to premium increases.⁴¹

Second, older and sicker beneficiaries are more likely to incur greater medical expenses than the average TRICARE user. In developing the Sustain the Benefit proposal, DOD did not conduct an analysis of the distribution of health care costs by age or health status of TRICARE beneficiaries. However, data on the health care costs by age and health status are available for the general population from the Medical Expenditure Panel Survey (MEPS), a set of surveys of families and individuals, their medical providers, and employers across the United States conducted by the Agency for Healthcare Research and Quality. According to the most recent MEPS data, the reported average health care costs for individuals ages 60-64 in 2004 were more than twice as high as the reported costs for individuals ages 45-49. Moreover, in 2004 the reported health care costs for individuals who indicated that they were in poor health were more than 10 times as high as those for individuals who indicated that they were in excellent health.

In its technical comments, DOD stated that many beneficiaries are unable to anticipate being sicker than average. While this is true, the lack of a limited enrollment period for TRICARE Standard and Extra would allow these beneficiaries to enroll in TRICARE whenever they choose to do so. Therefore, DOD's projected savings per avoided user may be overestimated because healthy individuals who are eligible for TRICARE may initially choose not to enroll in the program—avoiding associated enrollment fees—until confronted with a costly medical condition, at which point they could choose to enroll in TRICARE Standard and Extra. DOD officials told us that they are considering limiting the enrollment period for TRICARE Standard and Extra to an annual or semiannual open-enrollment period; however, as of March 2007 no final decision had been made.

⁴¹See, for example, B.A. Strombom, T.C. Buchmueller, and P.J. Feldstein, "Switching Costs, Price Sensitivity, and Health Plan Choice," *Journal of Health Economics*, vol. 21, no. 1 (2002): 89-116 and A.B. Royalty and N. Solomon, "Health Plan Choice: Price Elasticities in a Managed Competition Setting," *The Journal of Human Resources*, vol. 34, no. 1 (1999): 1-41.

Revenues from Higher Enrollment Fees and Deductibles Would Likely Be between \$1.9 Billion and \$2.3 Billion, Depending on the Number of Avoided Users

DOD expects to collect \$1.9 billion in revenues from retirees and dependents under 65 who remain in TRICARE and who would pay higher enrollment fees and deductibles under Sustain the Benefit. The estimate of \$1.9 billion depends on DOD achieving its projected number of 500,000 avoided users from Sustain the Benefit. However, if DOD does not generate as many avoided users as projected, the increase in revenue would be higher than \$1.9 billion, because DOD would collect higher enrollment fees and deductibles from a greater number of beneficiaries. We estimated that if the higher enrollment fees and deductibles do not result in any avoided users, the increase in collected revenue would likely amount to \$2.3 billion over 5 years.

This \$2.3 billion figure also represents the minimum total savings that are likely to result from the proposed enrollment fee and deductible increases, if these changes do not generate any avoided users. However, Sustain the Benefit would be likely to generate some avoided users, and any savings associated with each avoided user would increase total savings in excess of \$2.3 billion. With each avoided user, total savings would increase because the average savings generated from each avoided user would be higher than the associated reduction in revenue from the user no longer paying enrollment fees and deductibles.

A Lack of Data on TRICARE Beneficiaries Prevents a More Accurate Estimate of Likely Savings from Proposed Fee and Deductible Increases

While we estimate that DOD would achieve \$2.3 billion or more from the proposed fee and deductible increases, we cannot make a more accurate estimate of these savings, in part because DOD does not collect and compile certain data from TRICARE beneficiaries—data that DOD could have used to make the projections for Sustain the Benefit more accurate.⁴² In particular, DOD officials told us that the department does not collect and compile data from TRICARE beneficiaries on the cost of premiums in non-TRICARE health insurance programs available to them. In addition, for Sustain the Benefit, DOD did not collect information on why beneficiaries choose to use or not to use TRICARE. This information could be used to help better predict how beneficiaries might react to changes in TRICARE's cost-sharing structure, such as the number of avoided users that might result from TRICARE enrollment fee increases. RAND recently surveyed military retirees under age 65 and collected some of this

⁴²DOD routinely collects data about its beneficiaries, such as their satisfaction with TRICARE, through surveys. DOD is required by law to conduct an annual survey to collect certain information from beneficiaries and may also collect additional information on other matters through those surveys, as appropriate. See 10 U.S.C. § 1071, note.

information for its draft report. However, this information was compiled after DOD developed its Sustain the Benefit proposal, and it does not include some important information. RAND researchers stated that data on premiums for other health insurance plans available to TRICARE beneficiaries, relative to their available financial resources, and reasons why beneficiaries choose to enroll in TRICARE Prime would be necessary to fully model the effects of increases in TRICARE cost shares. They recommended a follow-up survey of military retirees under age 65, aimed at collecting this information.

Savings from Increased Pharmacy Co-payments Are Likely Overestimated, although Some Savings Can Be Expected

DOD is unlikely to achieve the \$1.5 billion it expects to receive by increasing retail pharmacy co-payments for all beneficiaries except active duty personnel.⁴³ DOD projected that implementing the proposed higher co-payments would both reduce demand for prescription drugs purchased in retail pharmacies and encourage TRICARE beneficiaries to use MTF pharmacies and TMOP instead of relatively more expensive retail pharmacies, resulting in \$982 million in savings. DOD's estimate of \$982 million in savings is likely too high because fewer beneficiaries than DOD projects are likely to reduce their use of retail pharmacies. If more beneficiaries continue to use retail pharmacies and pay higher co-payments, DOD will receive more than the estimated \$486 million in increased revenue that the department expects. However, the increased revenue collected from these co-payments would not be large enough to offset the cost of providing these beneficiaries' prescriptions through higher-cost retail pharmacies.

⁴³DOD also expects that there will be savings of \$1.5 billion over 5 years because of pharmacy co-payment increases for retirees and dependents over 65 in TRICARE for Life. However, DOD officials told us that they did not include this amount in DOD's estimate of savings because TRICARE for Life costs are paid through the Department of Defense Medicare Eligible Retiree Health Care Fund. See 10 U.S.C. §§ 1111 et seq.

DOD's Estimate of Savings Resulting from Beneficiaries' Response to Increased Retail Pharmacy Co-payments Is Likely Too High

DOD projected that \$982 million in savings from the proposed increases in retail pharmacy co-payments would result from beneficiaries' reactions to the increased co-payments. Specifically, DOD projected that some beneficiaries would reduce their demand for prescription drugs purchased in retail pharmacies and increase their use of MTF pharmacies and TMOP instead of relatively more expensive retail pharmacies. However, DOD's estimate of \$982 million is likely too high because DOD based the estimate on results from a study⁴⁴ of non-DOD employer-sponsored health insurance plans that was not analogous to DOD's situation. The study included savings from individuals who shifted from brand-name to less expensive generic drugs, but DOD already generally requires beneficiaries to use generic drugs when available. Specifically, the study measured how increases in the co-payments for brand-name and generic prescription drugs affected prescription drug spending in employer-sponsored health insurance plans. However, the cost-sharing structures and options for obtaining prescriptions in the plans included in the study were different from those in TRICARE. DOD relied on this study because no studies were available that directly applied to its situation. The study reported a percentage decrease in prescription drug spending because of increased co-payments. However, DOD applied this percentage as a decrease in the number of retail prescriptions. Doing so is incorrect—and overestimates the reduction in demand for prescription drugs obtained at retail pharmacies—because a portion of the percentage decrease in prescription drug costs reported in the study resulted from individuals shifting from brand-name to less expensive generic drugs. DOD cannot expect significant additional savings from beneficiaries shifting from brand-name to generic prescriptions because TRICARE already generally requires beneficiaries to use generic drugs when available.⁴⁵ Therefore, DOD's projected savings are likely to be lower than the savings projected in the study. In its technical comments, DOD stated that the study did not find savings from increased pharmacy co-payments to be caused by an increased use of generic drugs and that savings were similar among plans that required beneficiaries to use generic drugs when available and plans that did not. Although the study is somewhat ambiguous on this point, a discussion with the study's main author indicated that DOD's use of the study's results likely overestimated the savings from increased retail pharmacy co-payments.

⁴⁴Joyce and others.

⁴⁵A clinical justification for the use of a brand-name drug may be made under procedures prescribed by DOD. See 32 C.F.R. § 199.21(j).

DOD's projection of \$982 million in savings depends on a reduction in the number of prescriptions obtained at retail pharmacies over 5 years. DOD projected that about two-thirds of these prescriptions would instead be obtained from MTF pharmacies or TMOP, and projected that about one-third would not be obtained through TRICARE. However, neither we nor DOD have data to accurately project the number of beneficiaries who would be likely to obtain prescriptions at MTFs or TMOP instead of retail pharmacies. It is likely that some beneficiaries would increase their use of MTF pharmacies and TMOP because these options would continue to be less expensive than retail pharmacies. However, the exact number and associated savings cannot be estimated accurately because of the lack of data.

Although DOD May Collect More Revenue Than Projected from Higher Co-payments, the Increase Would Not Be Sufficient to Offset the High Cost of Retail Pharmacies

If fewer beneficiaries than DOD projected choose to reduce retail pharmacy use, then more beneficiaries would pay the higher co-payments, generating more revenue than the \$486 million over 5 years that DOD estimated.⁴⁶ DOD calculated this estimate by determining the additional amount of co-payments that would be paid by beneficiaries who continue to obtain prescriptions at retail pharmacies. If more beneficiaries than DOD projected continue using retail pharmacies, then revenues would be higher because more beneficiaries would pay higher retail pharmacy co-payments. However, the increased revenue collected from these co-payments would not be large enough to offset the higher cost of providing these beneficiaries' prescriptions through retail pharmacies. For example, DOD would collect an additional \$6 for each brand-name prescription drug and \$2 for each generic drug that beneficiaries would obtain from retail pharmacies if Sustain the Benefit were enacted. However, based on DOD data, we estimated that it would save an average of \$29 for each prescription that is no longer dispensed at a retail pharmacy. Some of these prescriptions would instead be dispensed through TMOP or MTFs.⁴⁷

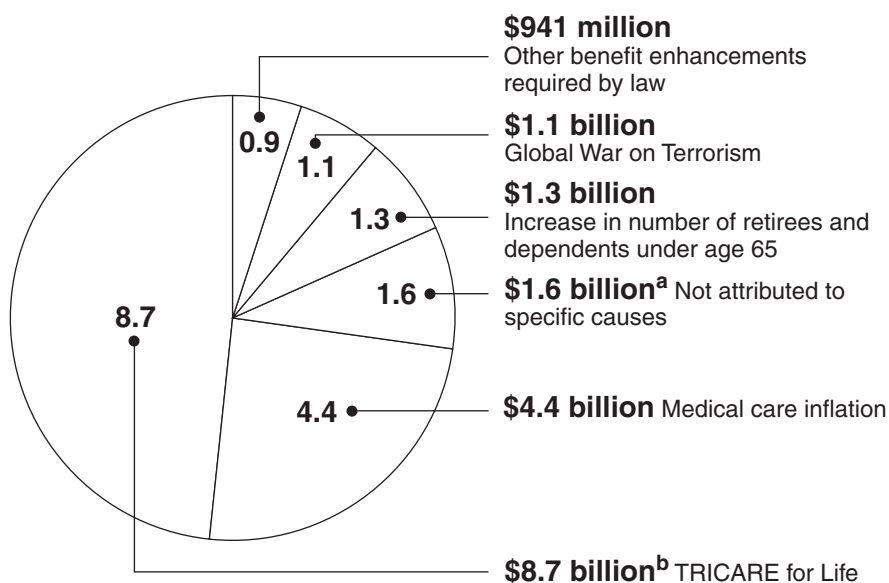
⁴⁶DOD's estimate of savings from increased retail pharmacy co-payments also depends on the number of avoided users generated by increased enrollment fees and deductibles for retirees and dependents under 65. If there are some avoided users, the population of beneficiaries who would be affected by increased retail pharmacy co-payments would be decreased, which would result in a reduction in savings from higher retail pharmacy co-payments. However, the reduction in savings from higher retail pharmacy co-payments would not be high enough to offset the savings from avoided users.

⁴⁷In calculating its data on average costs, DOD assumed that it would receive federal pricing discounts at retail pharmacies, although it currently does not receive these discounts.

Medical Care Inflation, Benefit Enhancements, and Other Factors Drove the Increase in DOD Health Care Spending from 2000 to 2005

DOD estimated that from 2000 to 2005, its health care spending increased by \$18.0 billion, from \$17.4 billion to \$35.4 billion, and that this increase was driven by several factors: medical care inflation; benefit enhancements required by law, including TRICARE for Life; increasing numbers of beneficiaries who choose to use TRICARE; and GWOT (see fig. 4). According to DOD, increases in its overall health care spending are reflected in spending for each of its beneficiary groups—active duty personnel, their dependents, retirees and dependents under age 65, and retirees and dependents in TRICARE for Life.

Figure 4: Factors Identified by DOD as Contributing to the Increase in Its Health Care Spending, 2000-2005



Source: GAO analysis of DOD data.

^aDOD officials believe that the “not attributed to specific causes” category is driven by additional medical care inflation beyond DOD’s estimated amount of \$4.4 billion, increasing use of health care services, technological advancements in treatment, and decreasing portions of costs paid by beneficiaries.

^bThe \$8.7 billion increase in spending for TRICARE for Life is based on contributions DOD has made to the DOD Medicare Eligible Retiree Health Care Fund.

DOD estimated that medical care inflation accounted for \$4.4 billion of the \$18.0 billion increase in its health care spending from 2000 to 2005. According to DOD, medical care inflation—increases in cost over time for delivering a fixed set of medical goods and services—averaged 4.6 percent per year. According to DOD officials, the department did not develop this estimate of medical care inflation based on its own spending. Instead,

DOD based this estimate on information provided annually by the Office of Management and Budget (OMB) on inflation rates for the various components of the TRICARE operating budget, such as military personnel assigned to MTFs, private sector health care, and pharmaceuticals.⁴⁸

However, an additional portion of DOD's spending increase may also be caused by medical care inflation. DOD officials identified \$1.6 billion in spending increases—classified as residual—that DOD could not attribute directly to specific causes. DOD officials stated that a portion of the residual could also be the result of medical care inflation. If the residual category is included with DOD's estimate of medical care inflation, then medical care inflation could account for up to \$6.0 billion of the increase in DOD health care spending from 2000 to 2005. This could add up to 1.5 percent to DOD's average annual rate of medical care inflation, making the total as much as 6.1 percent per year. However, DOD officials told us that they believe a large portion of the residual is caused by factors other than medical care inflation, such as an increasing use of health care services by beneficiaries, technological advancements in treatment, and decreasing portions of health care costs paid by TRICARE beneficiaries.⁴⁹ Our prior work on TRICARE has noted that a factor similar to DOD's residual—technology and intensity—is widely recognized as one that reflects growth in health care costs and often accounts for an additional 1 or 2 percent beyond medical care inflation in the private and public sectors.⁵⁰ As health care providers adopt new and expensive medical technologies and offer more intensive patient treatment, health care costs can increase at rates above the rate of medical care inflation. (See app. II for information on how DOD's estimated rate of medical care inflation compares to health insurance premium growth trends and broader indicators of inflation.)

DOD attributed a total of \$9.6 billion of the increase in its health care spending to benefit enhancements required by law—\$8.7 billion for

⁴⁸As part of the annual budget process, OMB provides agencies with inflation rates for the various components of their budgets. The TRICARE operating budget is mostly supported by appropriations for Operation and Maintenance.

⁴⁹According to DOD officials, the residual also includes any spending not accounted for in the other categories, such as the spending for the global settlement to pay managed care support contract claims.

⁵⁰See GAO, *Defense Health Program: Future Costs Are Likely to Be Greater Than Estimated*, [GAO/NSIAD-97-83BR](#) (Washington, D.C.: Feb. 21, 1997).

TRICARE for Life and \$941 million to other enhancements to the TRICARE benefit required by law. DOD's estimate of \$8.7 billion in increased spending on TRICARE for Life, which was implemented in 2001, is based on contributions DOD has made to the DOD Medicare Eligible Retiree Health Care Fund, an accrual fund that pays costs for TRICARE for Life.⁵¹ Since TRICARE for Life's initial implementation and 2005, the increase in DOD's spending represented by payments to the accrual fund was \$8.7 billion.⁵² In addition to its spending on TRICARE for Life, DOD estimated that its spending increased by \$941 million from 2000 to 2005 because of other enhancements to TRICARE required by law, such as the reduction of the TRICARE Standard and Extra catastrophic cap from \$7,500 to \$3,000 for retirees and dependents under age 65 and the elimination of TRICARE Prime co-payments for active duty dependents. According to DOD, the \$941 million is based on cost estimates of benefit enhancements before they were implemented. DOD did not determine actual spending on these benefit enhancements. CBO cost estimates done at about the same time project lower costs for some benefit enhancements. CBO officials also questioned the appropriateness of using cost estimates completed prior to implementation to estimate actual program costs because they are often based on incomplete information about a program. DOD officials have estimated spending on some of these enhancements after their implementation, but DOD officials told us that the department does not have the information systems necessary to precisely determine the spending because of the enhancements.

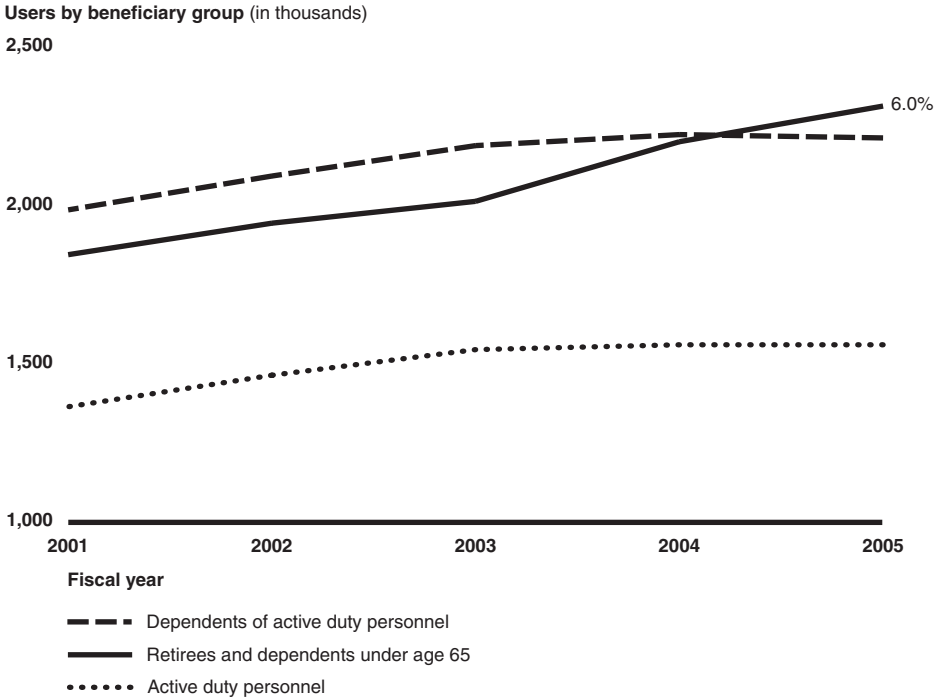
DOD estimated that an increase in the number of retirees and dependents under age 65 accounted for \$1.3 billion of the \$18.0 billion increase in DOD health care spending from 2000 to 2005. DOD's ability to control its health care spending for this population depends to a large degree on the extent to which beneficiaries who currently do not use TRICARE later enter the program for care, generating more spending. Our analysis of DOD data

⁵¹Before the TRICARE for Life program was implemented, DOD provided care to these beneficiaries on a space-available basis in MTFs. DOD makes annual contributions to the accrual fund for the cost of medical benefits to be provided in retirement to certain active duty servicemembers and reservists. The U.S. Treasury also makes contributions to the fund to cover its unfunded liability, including liability for beneficiaries who are already retired.

⁵²DOD contributed about \$10.22 billion to the accrual fund in 2005, but DOD officials estimated that DOD would have spent approximately \$1.56 billion on increased MTF care if the TRICARE for Life benefit had not been implemented. Therefore, increased spending attributed to TRICARE for Life benefit amounts to \$8.66 billion as of 2005.

indicates that the number of retirees and dependents under age 65 increased 6.0 percent a year, on average, from 2001 to 2005. (See fig. 5.)

Figure 5: TRICARE Users by Beneficiary Group, 2001-2005



Source: GAO analysis of DOD data.

DOD attributed \$1.1 billion of the increase in its health care spending from 2000 to 2005 to health care costs associated with GWOT. According to DOD officials, the largest components of costs related to GWOT over this period were health care for mobilized National Guard and Reserve personnel and their families, pre- and postdeployment medical care for servicemembers, and filling vacated positions of deployed medical personnel. DOD was able to provide only limited documentation and description of how these estimates were calculated. We reported in September 2005 about numerous problems with DOD's processes for recording and reporting costs for GWOT. Factors affecting the reliability of DOD's reported costs included long-standing deficiencies in DOD financial management systems and business processes, the use of estimates instead of actual costs, and the lack of supporting documentation. We made several recommendations to DOD to improve the reliability and reporting of costs. These included using actual data

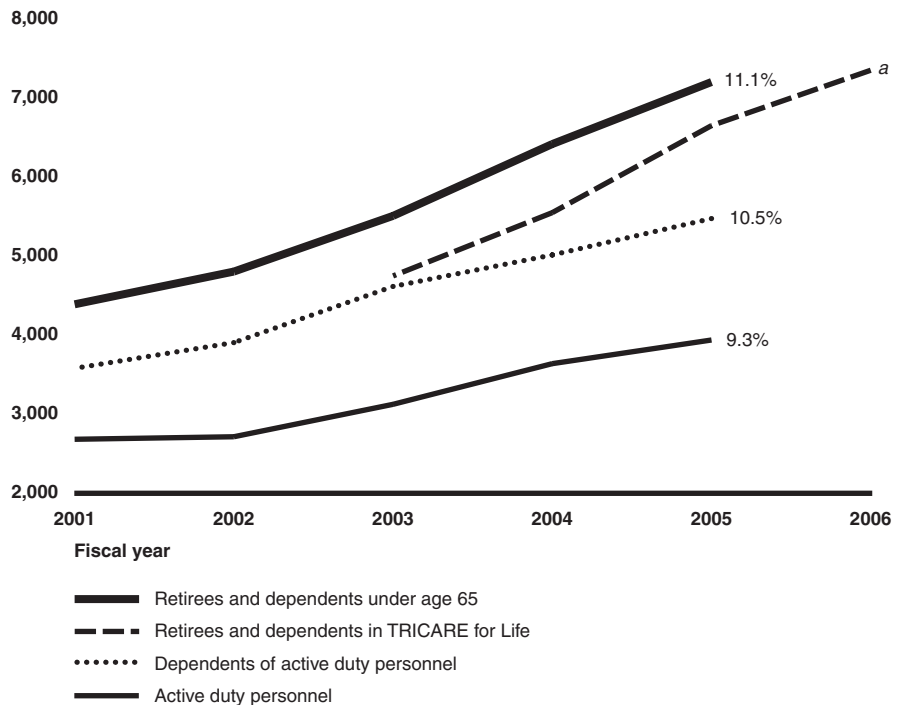
whenever possible and, when not possible, taking steps to allow the development of actual data.⁵³

The overall increase of \$18.0 billion in DOD health care spending from 2000 to 2005 is spread across each of DOD's beneficiary groups—active duty personnel, dependents of active duty personnel, retirees and dependents under age 65, and retirees and dependents in TRICARE for Life—each of which showed increases in overall spending and spending per beneficiary. Our analysis of DOD data on overall health care spending from 2001 to 2005 by beneficiary group indicated that total spending has increased by an average of 10.8 percent per year for active duty personnel, 11.7 percent for dependents of active duty personnel, and 13.6 percent for retirees and dependents under age 65. (See fig. 6.) A separate analysis indicated that total spending for retirees and dependents in TRICARE for Life increased at 16.2 percent per year, on average, from 2003 to 2006. During this time, DOD's spending per TRICARE beneficiary also increased. According to our analysis of DOD data, from 2001 to 2005, health care spending per beneficiary increased by an average of 7.3 percent per year for active duty personnel, 8.6 percent for dependents of active duty personnel, and 7.2 percent for retirees and dependents under age 65.

⁵³ [GAO-05-882](#) and [GAO-06-885T](#).

Figure 6: DOD Health Care Costs by Beneficiary Group, 2001-2005

Total government costs by beneficiary group (in millions)



Source: GAO analysis of DOD data.

^aThe costs for retirees and dependents in TRICARE for Life increased by 16.2 percent, on average, per year from 2003 through 2006.

Conclusions

DOD health care spending more than doubled from 2000 to 2005. In an effort to control this rapidly increasing health care spending, DOD has proposed increases to certain fees and co-payments that have remained unaltered for over 10 years. DOD's proposal would begin to narrow the price difference between TRICARE and civilian health insurance, which is consistent with DOD's priority of ensuring that TRICARE remains intact, affordable, and effective.

While the proposal would likely result in significant savings for DOD, DOD is unlikely to achieve the amount of savings it projected. In particular, DOD overestimated the amounts it would likely save from the increases in fees, deductibles, and retail pharmacy co-payments, in large part because of the difficulties in determining how beneficiaries will react to the increases. Determining how beneficiaries will react to changes in the TRICARE benefit—such as the number who would be likely to leave or

choose not to enroll in TRICARE because of increased enrollment fees and deductibles—can be important for understanding the effects of implementing benefit changes. Although DOD routinely collects and compiles some information from its TRICARE beneficiaries, it does not collect and compile information on beneficiaries’ access to and cost of other health insurance, or other information on reasons why beneficiaries may or may not choose to use TRICARE. This information would allow DOD to more accurately predict beneficiaries’ likely responses to changes in TRICARE and could help DOD manage its health care spending.

Recommendation for Executive Action

To help DOD manage its health care spending, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to collect and compile information that could help DOD identify the reasons why beneficiaries may or may not choose to use TRICARE. Such data could include beneficiaries’ access to and cost of other health insurance.

Agency Comments and Our Evaluation

We received written comments on a draft of this report from DOD. DOD stated that it concurs with our conclusions and recommendation. DOD expressed concern that the report leaves the impression that savings from DOD’s proposed cost share increases may be as low as \$2.3 billion. As stated in the draft report, we estimate that even with no avoided users, the enrollment fee and deductible portion of DOD’s proposed cost share increases would likely achieve a minimum of \$2.3 billion in savings over 5 years. We state that DOD’s savings will likely be higher than this minimum because the proposal should result in some avoided users. However, neither we nor DOD are able to make a more accurate estimate of these savings. DOD’s concern highlights the importance of our recommendation. Because the available information did not allow us or DOD to make a more accurate estimate of savings, we recommend that DOD collect and compile information that could help identify the reasons why beneficiaries may or may not choose to use TRICARE, such as beneficiaries’ access to and cost of other health insurance. DOD’s written comments are reprinted in appendix IV. DOD also provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Defense and other interested parties. We will also make copies available to others on request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7101 or ekstrandl@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix V.

A handwritten signature in black ink, reading "Laurie E. Ekstrand". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

Laurie Ekstrand
Director, Health Care

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The Honorable John McCain
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United States Senate

The Honorable Daniel Inouye
Chairman
The Honorable Ted Stevens
Ranking Member
Subcommittee on Defense
Committee on Appropriations
United States Senate

The Honorable Ike Skelton
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The Honorable Duncan Hunter
Ranking Member
Committee on Armed Services
House of Representatives

The Honorable John P. Murtha
Chairman
The Honorable C. W. Bill Young
Ranking Member
Subcommittee on Defense
Committee on Appropriations
House of Representatives

Appendix I: DOD's Calculation of the Portion of TRICARE Costs Being Paid by Retirees and Dependents under Age 65

To demonstrate the need for its Sustain the Benefit proposal, Department of Defense (DOD) officials calculated the proportion of health care costs paid by retirees and dependents under age 65 in 1996 and 2005. We were mandated to review these calculations.

DOD's calculations show that retirees and dependents under age 65 paid for approximately 27 percent of their overall health care costs in 1996, while they paid for around 12 percent in 2005. DOD based this calculation on the average out-of-pocket health care costs paid by a family of three and estimates of DOD's costs to provide health care to an average family of that size. DOD's calculations assume that the hypothetical family of three received all of its health care through civilian providers rather than military treatment facilities (MTF).¹ Had DOD included care received at MTFs in its calculation, the share of the cost paid by beneficiaries would have been even lower, because unlike civilian providers, MTFs do not charge co-payments or coinsurance.

Our review of DOD's calculation showed that DOD used different methods to calculate beneficiaries' out-of-pocket costs in 1996 than it used for 2005. DOD officials told us that they used the best available data for each year. Certain information, such as individual claims data used to estimate the average costs paid per beneficiary in 2005, was not available for 1996. Instead, for TRICARE Standard and Extra users DOD estimated average costs paid by beneficiaries in 1996 by allocating TRICARE's total health care costs paid to civilian providers for that year among the total number of Standard and Extra users and estimating the average family of three's out-of-pocket costs, including deductibles and coinsurance based on these data and the assumption that all care was received from civilian providers.

To ensure consistency, we asked DOD officials to recalculate the proportion of health care costs paid by retirees and their dependents under age 65 who were Standard and Extra users in 2005 using the same methods that they used for the 1996 calculation. We then reviewed the results of this calculation. These results were very similar to DOD's original calculation, but were different in two ways. First, the new

¹For the calculation, DOD officials assumed that TRICARE Prime users received all of their care from participating TRICARE network providers and that TRICARE Standard and Extra users received all of their care from nonnetwork providers in 1996 and 50 percent of their care from network providers and 50 percent from nonnetwork providers in 2005.

**Appendix I: DOD's Calculation of the Portion
of TRICARE Costs Being Paid by Retirees and
Dependents under Age 65**

calculation produced a 2005 estimated proportion of health care costs paid by beneficiaries that was slightly smaller than the proportion estimated using DOD's original calculation. Second, the new calculation showed that the proportion decreased by a slightly larger amount over the same period.

Appendix II: Comparison of DOD Medical Care Inflation with Insurance Premium Growth and Broader Inflation Indicators

The John Warner National Defense Authorization Act for Fiscal Year 2007 required that we describe how DOD's annual rate of medical care inflation compares with increases in health insurance premium growth trends and broader indicators of inflation from 2001 through 2005.¹ To respond to this requirement, this appendix compares DOD's estimated annual rate of medical care inflation with premium growth trends among non-TRICARE health insurance, including the Federal Employees Health Benefits Program (FEHBP) and other programs, and indicators of inflation in broader sectors of the economy from 2001 through 2005. The methods used by DOD to estimate its annual rate of medical care inflation are not strictly comparable to the methods used to calculate more widely used price indexes, such as the Consumer Price Index (CPI). Price indexes such as CPI and its components, including the medical care component, are constructed from detailed data on the prices of a fixed set of goods and services of constant quantity and quality bought on average by urban consumers over time. DOD did not develop its estimate of inflation based on its own spending. Instead, DOD based the estimate on inflation rates provided annually by the Office of Management and Budget for the various components of the TRICARE operating budget, such as military personnel, private sector health care, and pharmacy. To facilitate the comparison, we gathered premium data, including FEHBP premium trend data from the Office of Personnel Management; premium data from the California Public Employees' Retirement System (CalPERS)—the second largest public purchaser of employee health benefits; and premium levels from surveys of employer-sponsored health plans from the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET). We also gathered information on broader indicators of inflation from the Bureau of Labor Statistics (BLS) on the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W), which is the basis for the annual cost of living adjustment (COLA) to cash pensions paid to military retirees,² and the medical care component of CPI-W.

Generally, the annual rate of medical care inflation estimated by DOD from 2001 to 2005 is lower than premium growth trends among FEHBP and other purchasers but higher than increases in broader indicators of

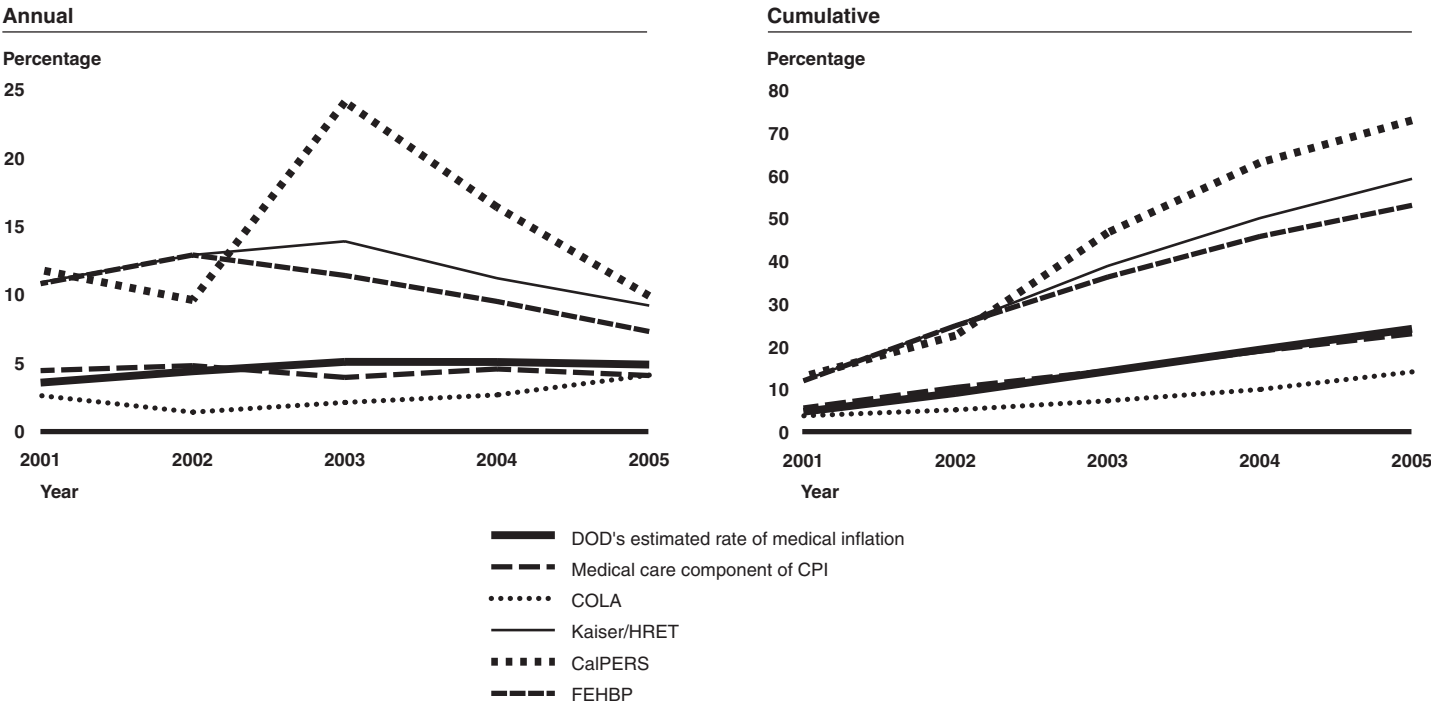
¹See Pub. L. No. 109-364, § 713(a)(2)(D), 120 Stat. 2083, 2289 (2006).

²For military personnel who first entered military service before August 1, 1986, each December a COLA equal to the percentage increase in CPI-W between the third quarters of successive years is applied to military retired pay for the annuities paid beginning each January 1.

Appendix II: Comparison of DOD Medical Care Inflation with Insurance Premium Growth and Broader Inflation Indicators

inflation. (See fig. 7.) However, these measurements are by definition very different from each other, so comparing them to each other can be problematic.

Figure 7: Comparison of DOD’s Estimated Rate of Medical Care Inflation, Health Insurance Premium Growth Trends, and Broader Indicators of Inflation



Source: GAO analysis of data from DOD, Kaiser/HRET, CalPERS, and BLS.

Notes: Cumulative growth reflects increases over the level of each measurement in 2000.

DOD calculated its average annual rate of medical care inflation to be about 4.6 percent per year from 2001 through 2005.³ Premium growth trends in FEHBP, the Kaiser/HRET survey of employer-sponsored health plans, and CalPERS ranged from 10.4 to 14.4 percent, on average, per year from 2001 to 2005. The average premium growth rate for the 10 largest FEHBP plans by enrollment—accounting for about three-quarters of total FEHBP enrollment—was 10.4 percent per year during this period. The average premium growth rate for surveyed employers was 11.6 percent per year and 14.4 percent per year for CalPERS.

Comparing DOD's annual rate of medical care inflation to premium growth trends and broader indicators of inflation is difficult because of differences in each measurement. Unlike medical care inflation, premium growth trends may reflect factors such as changes in the comprehensiveness of the policy, changes in the ratio of premiums collected to benefits paid, or changes in costs because of increased utilization of health care services. Therefore, it can be problematic to compare premium growth trends to DOD's estimated rate of medical care inflation. Broader indicators of inflation increased substantially slower than premium growth trends. In contrast, broader indicators of inflation, particularly the medical care component of CPI-W and the COLA, increased at lower rates than DOD's estimated rate of medical care inflation. The medical care component of CPI-W increased almost 2 percentage points per year faster than the COLA—4.4 percent per year compared to 2.5 percent per year, on average. The medical care component of CPI-W is based on medical care expenses, but it is difficult to compare with DOD's estimated rate of medical care inflation because it is based only on out-of-pocket medical expenditures paid by consumers, including health insurance premiums, and excludes the medical expenditures paid by public and private insurance programs. The COLA is also not directly comparable to DOD's estimated rate of medical care inflation because it is based on price increases of a broad range of goods and services, and is not based solely on medical expenses.

³DOD's rates of medical care inflation from 2001 through 2005 are based on inflation rates provided annually by the Office of Management and Budget for the various components of the TRICARE operating budget, such as military personnel assigned to MTFs, private sector health care, and pharmacy. As we note in this report, an additional portion of DOD's spending increase may also be caused by medical care inflation, making DOD's average annual rate of medical care inflation likely to be from 4.6 to 6.1 percent.

Appendix III: Scope and Methodology

To examine the DOD's estimated savings associated with enrollment fee and deductible increases for retirees and dependents under age 65 and pharmacy co-payment increases for all beneficiaries except active duty personnel, we reviewed the analyses prepared by DOD and its contractor that projected cost savings from these increases. We also interviewed DOD officials in the Office of the Assistant Secretary of Defense for Health Affairs, the Office of Program Analysis and Evaluation, and the Office of the Under Secretary of Defense (Comptroller). Furthermore, we reviewed literature from the field of health economics and interviewed six health economists to discuss economic principles relevant to our work, including price sensitivity for health insurance and prescription drugs and adverse and biased selection. We also reviewed survey data from (1) the Kaiser Family Foundation and Health Research and Educational Trust (Kaiser/HRET) on employer-sponsored insurance premiums, (2) the RAND Corporation (RAND) on the health insurance options of military retirees, and (3) the Agency for Healthcare Research and Quality (AHRQ) on health care costs for the U.S. population. We also reviewed a draft report prepared by RAND on the health insurance options of military retirees and Kaiser/HRET reports on employer health benefits. In addition, to identify concerns with DOD's Sustain the Benefit proposal and associated savings estimates, we interviewed representatives from the Reserve Officers Association, the National Association of Uniformed Services, the National Military Families Association, and The Military Coalition.

To examine the factors identified by DOD as contributing to the increase in TRICARE spending, we reviewed the factors that DOD identified as contributing to the increase in TRICARE spending from 2000 to 2005 and interviewed officials from the Office of the Assistant Secretary of Defense for Health Affairs. We determined that the spending data provided by DOD were sufficiently reliable for our purposes, but we did not independently verify DOD's figures. We also reviewed academic literature on medical care inflation.

Evaluation of Cost Savings Estimates

As part of our evaluation of DOD's estimate of beneficiary response to increases in TRICARE enrollment fees and deductibles and the cost savings attributable to these individuals, we reviewed data from several sources to conduct the following frequency analyses and cross tabulations.

We calculated the average cost of civilian health insurance premiums and how it compares to TRICARE enrollment fees by evaluating data on the cost of employer-sponsored insurance premiums reported in the

Kaiser/HRET annual employer health benefits survey. Using these data for 2000 through 2006, we determined the percentage of enrollees whose share of the employer-sponsored health insurance premium was lower than or equal to the TRICARE Prime and Standard and Extra enrollment fees for both single and family coverage.

We assessed characteristics of the military retiree population, including access to health insurance other than TRICARE, self-reported health status, age, and employment status, by reviewing data reported in RAND's draft report titled *Civilian Health Insurance Options of Military Retirees*. We also examined cross tabulations showing access to health insurance other than TRICARE by age and self-reported health status to determine whether older and less healthy individuals are less likely to have other health insurance options.

We examined health care spending for various groups within the U.S. population by reviewing data from the Medical Expenditure Panel Survey (MEPS), which is conducted by AHRQ. Using the results from the 2004 MEPS, we examined cross tabulations of health care expenditures by age and health status.

Our analysis was limited because neither we nor DOD were able to control for several important factors affecting beneficiaries' response to enrollment fee and deductible increases and the associated savings. For example, no data on TRICARE beneficiaries' sensitivity to cost-share increases is available because DOD has not attempted to increase fees since TRICARE's inception. Furthermore, although the RAND draft report includes information on access to civilian insurance plans among military retirees and their dependents under age 65, there are no data specific to this population on the cost of civilian health insurance plans available to them.

Data Reliability Tests

To ensure that the DOD data were sufficiently reliable for our analyses, we conducted detailed data reliability assessments of the data sets that we used. We restricted these assessments, however, to the specific variables that were pertinent to our analyses.

We reviewed DOD analyses that we determined to be relevant to our findings to assess their quality and methodological soundness. Our review consisted of (1) examining documents that describe the respective analyses, (2) manually and electronically checking the data for obvious errors and missing values, (3) interviewing DOD officials to inquire about

concerns we uncovered, (4) interviewing DOD officials about internal controls in place to ensure that data are complete and accurate, and (5) assessing the reasonableness of assumptions DOD made. To assess DOD assumptions, we reviewed relevant health economics literature and interviewed six health economists.

Our review revealed inconsistencies and minor errors in DOD's analyses that we reported to DOD officials. Overall, however, we found that all of the data sets used in this report were sufficiently reliable for use in our analyses.

We conducted our work from July 2006 through May 2007 in accordance with generally accepted government auditing standards.

Appendix IV: Comments from the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

MAY 11 2007

Ms. Laurie E. Ekstrand
Director, Health Care
U.S. Government Accountability Office
441 G. Street, N.W.
Washington, DC 20548

Dear Ms. Ekstrand:

This is the Department of Defense (DoD) response to the GAO draft report, GAO-07-647, "MILITARY HEALTH CARE: TRICARE Cost Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated," dated April 20, 2007 (GAO Code 290559).

Thank you for the opportunity to review the Draft Report and for GAO's review of this critically important topic. Overall, I concur (enclosed) with the report's conclusions and findings. Our technical comments on the draft report are enclosed.

While we understand that there may be differing opinions on the amount of the overall savings estimate, our concern is that without an independent estimate from GAO, the report leaves the impression that the savings from the premium/deductible changes may be as low as \$2.3B. While the detailed report hints that this is not the case, a stronger statement on the most likely effect or a range of the effect would have been more informative for the discussion on this important topic.

My points of contact on this action are Mr. Allen Middleton (Functional) at (703) 681-1724 and Mr. Gunther Zimmerman (Audit Liaison) at (703) 681-3492.

Sincerely,

S. Ward Casscell, MD

Enclosures:
As stated

GAO DRAFT REPORT DATED APRIL 20, 2007
GAO-07-647 (GAO CODE 290559)

**MILITARY HEALTH CARE: TRICARE Cost Sharing Proposals Would Help
Offset Increasing Health Care Spending, but Projected Savings Are Likely
Overestimated,**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE RECOMMENDATION**

RECOMMENDATION: To help DoD managed its health care spending, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to collect and compile information that could help DoD identify the reasons why beneficiary may or may not choose to use TRICARE. Such data could include beneficiaries' access to and cost of other health insurance.

DOD RESPONSE: Concur

Appendix V: GAO Contact and Staff Acknowledgments

GAO Contact

Laurie Ekstrand (202) 512-7101 or ekstrandl@gao.gov

Acknowledgments

In addition to the contact named above, Bonnie Anderson, Assistant Director; Thomas Conahan, Assistant Director; Timothy Carr; Timothy Cunningham; Krister Friday; Adrienne Griffin; William Simerl; Eric Wedum; and Michael Zose made key contributions to this report.

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